SMLE Questions Bank

Selected Questions

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Q1

A 1-year-old boy is brought to the pediatric clinic with a 3-week history of progressive abdominal distension and easy bruising. His parents have also noticed a painless swelling on the left side of his neck. On examination, he has marked hepatosplenomegaly and multiple ecchymoses over his extremities. There is a firm, non-tender cervical lymph node measuring 3 cm in diameter. The pediatrician is concerned about an underlying hematologic malignancy and wants to confirm the diagnosis and subtype the disorder to guide therapy. What is the most appropriate next investigation?
A. Bone marrow aspiration
B. Lumbar puncture
C. EBV serology
D. MRI of the thorax
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Q2

A 46-year-old man with a 20-year history of smoking and daily alcohol intake presents to the clinic with several months of fatigue. He denies jaundice, abdominal distension, gastrointestinal bleeding, or weight loss. Physical examination is unremarkable with no ascites, spider angiomas, or hepatomegaly. Routine blood work shows elevated AST, mildly elevated ALT, and a markedly elevated serum ferritin level. Viral hepatitis panel is notable for positive hepatitis B surface antibody (HBsAb) and negative HBsAg, consistent with immunity from past infection or vaccination. Ultrasound shows a coarse, nodular liver compatible with cirrhosis. Which of the following is the most likely underlying cause of this patient’s liver cirrhosis?
A. Hereditary hemochromatosis
B. Chronic hepatitis B infection
C. Chronic alcohol use
D. Nonalcoholic fatty liver disease
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Q3

A preterm male neonate is being discussed on morning rounds in the NICU. Vital signs are: T: 36.8 °C, BP: 58/32 mmHg, HR: 148 /min, RR: 46 /min, SpO2: 96% (on room air). The attending asks the residents about conditions that predispose infants to necrotizing enterocolitis, a severe gastrointestinal emergency characterized by feeding intolerance, abdominal distension, and pneumatosis intestinalis on imaging. Which of the following is a recognized risk factor for developing necrotizing enterocolitis in newborns?
A. Low birth weight
B. Term gestation
C. Exclusive breastfeeding
D. Maternal diabetes mellitus only
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Q4

A 30-week gestation preterm male infant weighing 1300 g is being cared for in the NICU. On day 5 of life, he develops abdominal distension and bloody stools and is diagnosed with necrotizing enterocolitis. His current vital signs are: T: 37.4 °C, BP: 60/35 mmHg, HR: 168 /min, RR: 54 /min, SpO2: 95% (on nasal CPAP). The parents ask what the strongest risk factor was for this condition in their baby. Which of the following is the strongest risk factor for necrotizing enterocolitis in this infant?
A. Cesarean delivery
B. Low birth weight (1300 g)
C. Maternal gestational diabetes
D. Intrapartum maternal fever

Q5

A 42-year-old man presents to the hepatology clinic to discuss treatment options after being diagnosed with chronic hepatitis C virus (HCV) infection during routine screening for mildly elevated liver enzymes. He reports intermittent fatigue but denies jaundice, abdominal distension, or GI bleeding. He does not drink alcohol and has no history of IV drug use. Physical examination shows no stigmata of chronic liver disease (no ascites, spider angiomas, palmar erythema, or hepatosplenomegaly). Abdominal ultrasound is normal with no evidence of cirrhosis or portal hypertension. Lab results show: AST 65 U/L, ALT 78 U/L, total bilirubin 0.9 mg/dL, albumin 4.2 g/dL, INR 1.0, platelets 240,000/µL. HCV RNA viral load is 2 million IU/mL. There is no evidence of hepatitis B or HIV coinfection. What is the most appropriate next step in management?
A. Initiate pegylated interferon and ribavirin therapy
B. Start entecavir therapy
C. Start sofosbuvir/ledipasvir therapy
D. Defer therapy and repeat HCV RNA and liver enzymes in 3 months

Q6

A 60-year-old postmenopausal woman presents to her gynecology clinic with 3 months of lower abdominal discomfort, early satiety, and mild abdominal distension. She denies vaginal bleeding or weight loss. On pelvic examination, there is a nontender, solid, irregular right adnexal mass that is distinct from the uterus. Speculum examination is unremarkable, and her Pap smear performed 1 year ago was normal. Transvaginal ultrasound confirms a predominantly solid, irregular right adnexal mass with minimal ascites. The gynecologist is concerned about primary epithelial ovarian cancer and wants to order a serum tumor marker to aid in preoperative risk assessment. What is the SINGLE most appropriate tumor marker to request for?
A. CA 125
B. Carcinoembryonic antigen (CEA)
C. Alpha-fetoprotein (AFP)
D. Beta-human chorionic gonadotropin (β-hCG)

Q7

A 72-year-old postmenopausal woman presents with progressive abdominal distension and shortness of breath over the past few weeks. Examination shows shifting dullness indicating

ascites and decreased breath sounds at the right lung base. Imaging reveals a right-sided pleural effusion, moderate ascites, and a complex right adnexal mass. There is no obvious uterine or cervical lesion on pelvic examination. Which is the most likely primary site of malignancy?
A. Ovarian
B. Cervical
C. Endometrial
D. Uterine (myometrial)

Q8

A public health researcher is evaluating the burden of colon cancer in a community of 100,000 adults over a 1■year period. During this year, 300 new cases of colon cancer are diagnosed, and at the start of the year there are 75 individuals already known to have colon cancer. She wants to calculate the cumulative prevalence of colon cancer in this population during that year. Which of the following values best represents the cumulative prevalence?
A. 0.375%
B. 0.45%
C. 0.375 per 1000
D. 0.45 per 1000

Q9

A 1-year-old boy is brought to the emergency department by his mother because she noticed that over the past week he has been dragging his left leg and seems weaker on that side. Pregnancy and delivery were uncomplicated, and his immunizations are up to date. On presentation, his vital signs are: T: 36.8 °C, BP: 88/56 mmHg, HR: 112 /min, RR: 24 /min, SpO2: 99% on room air. On examination, he is alert and afebrile, with mild weakness of the left lower limb but no cranial nerve deficits. Abdominal examination reveals a firm, irregular, non-tender mass palpable in the left side of the abdomen. CT scan of the abdomen and pelvis demonstrates a heterogeneous mass arising from the paravertebral sympathetic chain, with extension into the retroperitoneum. Which of the following is the most likely diagnosis?
A. Retinoblastoma
B. Neuroblastoma
C. Wilms tumor
D. Hepatoblastoma

Q10

A 2-week-old boy is brought to the emergency department after a prenatal ultrasound reportedly showed unilateral hydronephrosis. Postnatal renal ultrasound confirms moderate hydronephrosis of the left kidney and a bladder wall that appears thicker than normal. He is afebrile and feeding well. Vital signs: T 36.8 °C, BP 72/42 mmHg, HR 140/min, RR 34/min, SpO2 99% (RA). On examination, he has mild left flank fullness and tenderness but no abdominal masses, and his external genitalia are normal. A urinalysis shows no hematuria or signs of infection. The team wants to identify the level of urinary tract obstruction and assess drainage from the kidney to guide further management. What is the highest-yield next diagnostic investigation?
A. Intravenous pyelogram

B. Renal biopsy
C. DMSA renal cortical scan
D. Diuretic renal scintigraphy (MAG3 or similar)

Q11

A 27-year-old woman presents to the emergency department with 2 days of lower abdominal pain, nausea, vomiting, and constipation. Her last menstrual period was 6 weeks ago, and she is sexually active with inconsistent contraception use. Vital signs: T: 37.2 °C, BP: 118/72 mmHg, HR: 92/min, RR: 16/min, SpO2: 99% RA. A CT scan of the abdomen and pelvis was obtained before her pregnancy status was known. Before proceeding with further imaging interpretation and management, which of the following is the most important additional investigation that should be performed now?
A. Complete blood count
B. Urinalysis
C. Serum pregnancy test
D. Serum amylase and lipase

Q12

A 25-year-old nulligravid woman presents to the emergency department with 6 weeks of amenorrhea, lower abdominal pain, and light vaginal spotting. Her urine pregnancy test is positive. Transvaginal ultrasound shows no intrauterine gestational sac and a right adnexal mass consistent with an ectopic pregnancy. Her vital signs are: T: 36.9 °C, BP: 118/72 mmHg, HR: 78 /min, RR: 14 /min, SpO2: 99% on room air. She is hemodynamically stable and asks what factors might have increased her risk for this condition. Which of the following is the most important risk factor for ectopic pregnancy?
A. Induction of ovulation
B. Previous appendectomy
C. Past pelvic inflammatory disease
D. Current intrauterine device use

Q13

A 29-year-old G2P1 woman at 32 weeks' gestation presents to the obstetric triage unit with mild vaginal bleeding and lower abdominal pain for 2 hours. The bleeding is dark red and has soaked through one sanitary pad. She describes the pain as constant and crampy, not like contractions. Fetal movements are still perceived. Vital signs: T: 37.1 °C, BP: 100/65 mmHg, HR: 96/min, RR: 18/min, SpO2: 98% on room air. On abdominal examination, the uterus is firm and tender to palpation, and there is no obvious uterine relaxation between contractions. Speculum examination shows a small amount of dark blood in the vagina without active brisk bleeding; digital cervical examination is deferred. Which of the following is the most likely diagnosis?
A. Placental abruption
B. Placenta previa
C. Vasa previa
D. Uterine rupture

Q14

A 21-year-old woman, G1P1, presents to the emergency department with 1 day of sudden-onset severe abdominal pain associated with nausea and multiple episodes of vomiting. The pain began around the periumbilical region and has now localized to the right lower quadrant, extending toward the right iliac fossa. She denies vaginal bleeding or discharge and reports her last menstrual period was 2 weeks ago. She is sexually active and uses barrier contraception. A urine pregnancy test is negative. Vital signs: T: 38.1 °C, BP: 112/70 mmHg, HR: 104 /min, RR: 18 /min, SpO2: 99% (RA). On examination, she has localized tenderness and guarding in the right lower quadrant, maximal at McBurney point, without rebound in other quadrants. There is no cervical motion tenderness on pelvic examination. Which of the following is the most likely diagnosis?

A. Ectopic pregnancy
B. Acute appendicitis
C. Ovarian torsion
D. Request another diagnostic test

Q15

A 23-year-old nulliparous woman presents to the clinic with a 1-year history of progressively worsening crampy lower abdominal pain that begins 1–2 days before menses and continues through the first 3 days of bleeding. The pain is now interfering with her work and sleep. Her cycles are regular every 28 days with moderate flow and no intermenstrual bleeding. She is sexually active, uses condoms inconsistently, and is not currently planning pregnancy. Pelvic examination shows a normal-sized, anteverted, non-tender uterus with no adnexal masses or cervical motion tenderness. A urine pregnancy test is negative. She asks for treatment to relieve her menstrual pain and is open to medical therapy for contraception. Which of the following is the most appropriate next step in management?

A. Combined oral contraceptive pills
B. Reassurance only
C. Diagnostic laparoscopy
D. Pelvic MRI

Q16

A 24-year-old primigravida at a reported 37 weeks of gestation presents to the antenatal clinic with intermittent, mild lower abdominal pain but no vaginal bleeding or loss of fluid. Fetal movements are normal. She has had regular antenatal care but this is her first ultrasound in the third trimester. Vital signs are stable. Obstetric ultrasound shows a single live fetus with an anterior low-lying placenta completely covering the internal cervical os (placenta previa major). The estimated gestational age by ultrasound biometry is 32 weeks. There is no evidence of abruption, and the cervix appears closed. What is the most appropriate next step in management?

A. Observation and outpatient expectant management
B. Plan elective cesarean delivery at fetal maturity
C. Administer antenatal corticosteroids and continue pregnancy

D. Perform digital vaginal examination of the cervix

Q17

A 26-year-old man presents with a 6-month history of crampy right lower quadrant abdominal pain, non-bloody diarrhea, and a 5-kg unintentional weight loss. He also reports occasional low-grade fevers and fatigue. Colonoscopy with terminal ileoscopy shows patchy, transmural inflammation, cobblestoning, and areas of normal mucosa between inflamed segments. Biopsies confirm the diagnosis of Crohn disease. What is the most common site of involvement in this condition?
A. Jejunum
B. Ileum
C. Colon
D. Rectum

Q18

A 26-year-old woman presents to the emergency department with 6 hours of gradually worsening lower abdominal pain, a single episode of non-bilious vomiting, and constipation. She denies dysuria, vaginal bleeding, or discharge. Her last menstrual period was 5 weeks ago and she is sexually active without contraception. Vital signs: T: 37.4 °C, BP: 112/70 mmHg, HR: 88/min, RR: 16/min, SpO2: 99% on room air. Abdominal examination reveals mild suprapubic and left iliac fossa tenderness without guarding or rebound; bowel sounds are present. Pelvic examination shows no cervical motion tenderness and a closed cervical os. Urinalysis is unremarkable. What is the most appropriate next diagnostic step?
A. Discharge home with oral analgesics and outpatient follow-up
B. Contrast-enhanced CT scan of the abdomen and pelvis
C. Transvaginal pelvic ultrasound with pregnancy test
D. Plain abdominal radiograph (erect and supine)

Q19

A 62-year-old man is undergoing evaluation after a positive fecal immunochemical test during routine colorectal cancer screening. He has no abdominal pain, change in bowel habits, or weight loss. Colonoscopy reveals a 2.5-cm sessile polyp in the sigmoid colon. Biopsy and histology confirm that the lesion is an adenomatous polyp. Among the common histologic types of adenomatous polyps, which type carries the highest risk of malignant transformation?
A. Villous adenoma
B. Tubular adenoma
C. Tubulovillous adenoma
D. Hyperplastic polyp

Q20

A 32-year-old woman presents to the clinic with 1 week of lower abdominal pain. Vital signs: T: 37.1 °C, BP: 112/70 mmHg, HR: 82/min, RR: 14/min, SpO2: 99% on room air. She reports 2 months of amenorrhea and is sexually active without contraception. She had a ruptured appendix at age 14 that required emergency surgery. Her pain is localized to the right lower quadrant and has been gradually worsening, associated with mild spotting but no dysuria, frequency, or urgency. On pelvic examination, there is right adnexal tenderness and mild cervical motion tenderness. A urine pregnancy test is positive. What is the most likely diagnosis?
A. Diverticulitis
B. Tubal (ectopic) pregnancy
C. Acute cystitis
D. Appendiceal abscess

Q21

A 28-year-old woman presents to the gynecology clinic with 3 days of worsening lower abdominal pain and new-onset brown, malodorous vaginal discharge. She had a copper intrauterine device (IUD) placed 2 weeks ago. She reports subjective fevers and pain with intercourse. She is sexually active with a new partner and inconsistently uses condoms. On examination, her abdomen is mildly tender in the suprapubic region without rebound or guarding. Speculum and bimanual examination show purulent brown cervical discharge and marked cervical motion tenderness, with bilateral adnexal tenderness. There is no vaginal bleeding, and the IUD strings are visible at the cervical os. A urine pregnancy test is negative.
What is the most likely diagnosis?
A. Uterine rupture
B. Pelvic inflammatory disease
C. Ectopic pregnancy
D. Physiologic post-insertion cramping and discharge

Q22

A 32-year-old multiparous woman presents 3 days after a suction evacuation for a first-trimester missed abortion with complaints of heavy, painless vaginal bleeding soaking a pad every 1–2 hours. She is hemodynamically stable and afebrile, with no abdominal pain or tenderness. Pelvic examination shows a slightly enlarged, nontender uterus and an open cervical os with active bleeding but no tissue seen at the os. The physician explains that this represents dysfunctional uterine bleeding following the procedure. What is the most appropriate next step in management?
A. Repeat dilation and curettage
B. Combined oral contraceptive pills
C. Uterine artery embolization
D. Hysterectomy

Q23

A 28-year-old G2P2 woman presents to the outpatient gynecology clinic with 3 days of lower abdominal pain and new-onset brown vaginal discharge. She had a copper intrauterine device (IUD) inserted 3 weeks ago. The pain is bilateral, dull, and worsens with intercourse. She has

low-grade fever and mild cervical motion tenderness on bimanual examination; the IUD strings are visible at the cervical os, and there is no vaginal bleeding. A urine pregnancy test is negative. What is the most likely diagnosis?
A. Uterine rupture
B. Pelvic inflammatory disease
C. Normal post-insertion IUD effects
D. Ectopic pregnancy

Q24

A 26-year-old G1P0 woman at 8 weeks' gestation presents with mild vaginal spotting for 1 day and no passage of tissue or clots. She has mild cramping but no severe abdominal pain. Speculum exam shows a small amount of blood in the vaginal vault, with a closed cervical os. Transvaginal ultrasound shows a single intrauterine gestational sac with a yolk sac and fetal pole with cardiac activity. What is the most likely diagnosis?
A. Complete abortion
B. Threatened abortion
C. Missed abortion
D. Anembryonic sac

Q25

A 27-year-old primigravida at 10 weeks' gestation presents to the antenatal clinic for a routine visit. She has no vaginal bleeding, no abdominal pain, and reports normal early pregnancy symptoms. On pelvic examination, the cervix is closed, and fetal cardiac activity is detected on ultrasound with an intact intrauterine gestational sac. There is no evidence of products of conception in the cervical canal or uterus apart from the normally developing pregnancy. Which of the following is the most appropriate classification of this pregnancy status?
A. Threatened abortion
B. Inevitable abortion
C. Incomplete abortion
D. Anembryonic pregnancy

Q26

A 34-year-old G2P0 woman at approximately 7 weeks by dates presents to the emergency department with vaginal spotting and increasing lower abdominal pain for 3 days. She has a known left tubal ectopic pregnancy diagnosed 1 week ago by transvaginal ultrasound, when her serum β-hCG was 1,600 IU/L and no intrauterine gestational sac was visualized. At that time, she was hemodynamically stable and opted for medical management with single-dose methotrexate. She returns now with persistent, severe left lower quadrant pain despite oral analgesics.
Vital signs: T: 37.1 °C, BP: 110/70 mmHg, HR: 98/min, RR: 18/min, SpO2: 99% on room air. Abdominal exam shows marked tenderness in the left lower quadrant with guarding but no obvious rebound; pelvic exam reveals cervical motion tenderness and left adnexal tenderness. Repeat serum β-hCG today is 6,000 IU/L. bedside ultrasound again shows no intrauterine pregnancy and a left adnexal mass with a small amount of free fluid in the pelvis.

What is the most appropriate next step in management?
A. Laparoscopic salpingostomy
B. Laparoscopic salpingectomy
C. Continue expectant management after methotrexate
D. Immediate exploratory laparotomy

Q27

A 26-year-old nulliparous woman presents to the gynecology clinic with 4 days of profuse yellow-green vaginal discharge and increasing lower abdominal pain. She is sexually active with multiple partners and uses condoms inconsistently. She reports fever and dyspareunia. Pelvic examination reveals copious mucopurulent discharge from the cervical os, marked cervical motion tenderness, and tenderness of the lateral vaginal fornices and adnexal regions bilaterally. Pregnancy test is negative. Which of the following is the most likely diagnosis?
A. Acute salpingitis
B. Acute cervicitis
C. Appendicitis
D. Endometriosis

Q28

A 21-year-old woman, G2P1, presents to the emergency department with severe lower abdominal pain for 1 day. The pain is dull, intermittent, lasts 10–15 minutes at a time, and is associated with nausea and vomiting. She denies dysuria, urinary frequency, or vaginal bleeding. Her last menstrual period was 3 weeks ago, and she is not using contraception. On examination, she appears uncomfortable and mildly diaphoretic.
Vital signs:
- T: 37.6 °C
- BP: 90/60 mmHg
- HR: 110 /min
- RR: 13 /min
- SpO2: 98% on room air

Abdominal examination reveals marked tenderness and guarding in the lower abdomen, more pronounced on the right side, with slight fullness in the right iliac fossa. Pelvic examination reveals right adnexal tenderness and fullness without cervical motion tenderness. Urine pregnancy test is negative.
Which of the following is the most likely diagnosis?
A. Acute cystitis
B. Ovarian torsion
C. Acute appendicitis
D. Ectopic pregnancy

Q29

A 4-year-old boy is brought to the clinic because his parents noticed bright red blood on the toilet paper and streaking the surface of his stool over the past 2 days. He has no abdominal pain,

vomiting, fever, weight loss, or change in appetite. His stools are otherwise normal in consistency and frequency, and he has no history of constipation or diarrhea. On examination, he is well-appearing, with normal growth parameters; abdominal examination is soft and nontender, and there is no palpable mass. Digital rectal examination reveals a small linear tear at the posterior midline of the anal verge with mild tenderness and a small amount of bright red blood. The physician reassures the parents that this is common in young children and can usually be prevented with stool softening and local care. What is the most likely diagnosis?
A. Anal fissure
B. Internal hemorrhoids
C. Juvenile polyp
D. Intussusception

Q30

A 30-year-old woman, G3P0A2, presents to the early pregnancy unit at 5 weeks' gestation with mild vaginal spotting for 1 day. She has no abdominal pain or cramping. Vital signs are stable. On speculum and bimanual examination, there is scant dark blood in the vagina, a slightly open cervical os, and no active bleeding from the cervix. Transvaginal ultrasound shows a small intrauterine gestational sac consistent with 5 weeks without fetal pole yet visualized. Her history is significant for 2 prior second-trimester pregnancy losses at around 18–20 weeks' gestation; the most recent loss required dilation and curettage, and she was told that she had an incompetent cervix. She is anxious about this pregnancy and asks what is the most likely diagnosis explaining her current presentation in the context of her past obstetric history.
A. Asherman syndrome
B. Incompetent cervix
C. Chromosomal anomaly
D. Threatened abortion

Q31

A 24-year-old man with no past medical or surgical history presents with crampy abdominal pain, vomiting, and abdominal distension. Imaging is consistent with small bowel obstruction. In the general adult population in developed settings, what is the most common cause of small bowel obstruction?
A. External hernia
B. Postoperative adhesions
C. Meckel diverticulum
D. Small bowel malignancy

Q32

A 46-year-old man comes to the clinic for a routine health maintenance visit. He feels well and has no gastrointestinal symptoms such as abdominal pain, change in bowel habits, rectal bleeding, or weight loss. He has no personal history of polyps, inflammatory bowel disease, or malignancy. His mother was diagnosed with colon cancer at age 69 and died 5 years later from metastatic disease. There is no other family history of colorectal cancer or polyposis syndromes. He does not smoke and drinks alcohol occasionally. Physical examination is unremarkable. He

asks what the most appropriate colorectal cancer screening strategy is for him at this time.
Which of the following is the best recommendation?
A. Colonoscopy every 5 years
B. Colonoscopy every 10 years
C. CT colonography every 10 years
D. Fecal immunochemical testing every 5 years

Q33

A 72-year-old man presents to the outpatient clinic with a 3-month history of progressive constipation and streaks of bright red blood on the stool. He denies weight loss or abdominal pain. Digital rectal examination reveals a firm irregular mass palpable on the posterior rectal wall. Colonoscopy shows a fungating lesion, and biopsy confirms adenocarcinoma located 6 cm from the anal verge. He has no significant comorbidities and is functionally independent. What is the most appropriate next step in management?
A. Proceed directly to low anterior resection
B. CT scan of chest and abdomen for staging
C. Neoadjuvant chemoradiotherapy to the pelvis
D. Start systemic chemotherapy immediately

Q34

A 13-year-old girl has a 10-month history of postprandial crampy periumbilical pain, 4–6 loose stools/day with occasional blood and mucus, 4-kg weight loss, and fatigue. She has mild pallor and diffuse abdominal tenderness (worst in the RLQ) with a perianal skin tag and fissure. Labs show anemia, ↑ESR, ↑CRP, low albumin, and elevated stool calprotectin; stool cultures and O&P are negative.
Upper endoscopy is normal. Colonoscopy reveals patchy erythema, aphthous ulcers, and skip lesions from the terminal ileum through segments of colon, with intervening normal mucosa; biopsies show transmural inflammation and noncaseating granulomas.
Which of the following is the most likely diagnosis?
A. Crohn disease
B. Ulcerative colitis
C. Peptic ulcer disease
D. Irritable bowel syndrome

Q35

A 29-year-old woman delivers a 1.3■kg male infant by emergency cesarean section at 29 weeks’ gestation due to preterm labor. On day 3 of life in the neonatal intensive care unit, the infant develops abdominal distension, feeding intolerance, and passage of bloody stools. Vital signs show T: 37.2 °C, BP: 60/35 mmHg, HR: 168/min, RR: 54/min, SpO2: 95% (on nasal cannula oxygen). Abdominal radiograph shows pneumatosis intestinalis consistent with necrotizing enterocolitis. Which of the following is the most important risk factor that predisposed this infant to develop this condition?
A. Male sex
B. Low birth weight

C. Bloody stool
D. Cesarean delivery

Q36

A 24-year-old G1P0 woman at 8 weeks of gestation presents to the emergency department with severe nausea and vomiting, lower abdominal pain, and heavy vaginal bleeding with passage of grape-like vesicles. Her family reports she has been rapidly gaining weight and appears more fatigued. Vital signs: T: 37.2 °C, BP: 140/90 mmHg, HR: 104 /min, RR: 18 /min, SpO2: 99% RA. On pelvic examination, the cervical os is open, with blood and vesicular tissue seen at the os; the uterus is enlarged to the size of a 12-week pregnancy and is diffusely tender. Quantitative serum β-hCG is markedly elevated for gestational age. Transvaginal ultrasound demonstrates a heterogeneous intrauterine mass with multiple cystic spaces producing a “snowstorm” appearance and no identifiable fetus. Which of the following is the most likely diagnosis?
A. Complete abortion
B. Incomplete abortion
C. Threatened abortion
D. Complete hydatidiform mole

Q37

A 24-year-old man presents to the clinic with 6 months of recurrent crampy abdominal pain and non-bloody diarrhea occurring 4–5 times per day. He has noted a 6-kg (13-lb) unintentional weight loss and increased fatigue. He reports occasional low-grade fevers and a feeling of fullness in the right lower abdomen. There is no recent travel history or sick contacts. Family history is notable for an uncle with inflammatory bowel disease of unclear type. On examination, he appears thin but in no acute distress; abdominal exam reveals mild tenderness and a vague fullness in the right lower quadrant without rebound or guarding. Perianal inspection reveals a small external opening with scant drainage near the anal verge consistent with a fistula. Laboratory studies show a mild microcytic anemia and elevated C-reactive protein. Colonoscopy demonstrates patchy areas of erythema and ulceration with normal intervening mucosa, most prominent in the terminal ileum, and biopsies show transmural inflammation and noncaseating granulomas. What is the most likely diagnosis?
A. Celiac disease
B. Crohn’s disease
C. Ulcerative colitis
D. Colonic dysentery

Q38

A 28-year-old G2P1 woman at 15 weeks of gestation comes for a routine prenatal visit. She feels well, with no vaginal bleeding or abdominal pain. Her first pregnancy and postpartum period were uncomplicated. On review of her initial prenatal labs from 8 weeks, her hemoglobin and hematocrit were within normal prepregnancy ranges. The obstetrician explains that normal pregnancy is associated with characteristic changes in blood volume and red cell mass that affect measured hemoglobin and hematocrit values. Which of the following best describes the

expected change in maternal hematologic parameters by the second trimester (around 15 weeks) in a normal pregnancy?
A. Increase in hematocrit by 20%
B. Decrease in hematocrit by 40%
C. Increase in plasma volume by about 40%
D. Decrease in plasma volume by about 40%

Q39

A 28-year-old woman presents with 2 weeks of crampy lower abdominal pain, bloody diarrhea, and tenesmus. She reports low-grade fever and weight loss over the past month. Physical examination shows mild diffuse lower abdominal tenderness without peritoneal signs. Vital signs: T: 38.5 °C, BP: 110/70 mmHg, HR: 98/min, RR: 18/min, SpO2: 98% on room air. Lab results: hemoglobin 9.8 g/dL, CRP 1.5 mg/dL (elevated), urea 60 mg/dL (elevated), WBC 11,500/µL. Colonoscopy demonstrates continuous mucosal inflammation starting from the rectum and extending proximally through the colon without skip lesions. Which is the most likely diagnosis?
A. Ulcerative colitis
B. Crohn’s disease
C. Celiac disease
D. Chronic bacillary dysentery

Q40

A 26-year-old sexually active woman presents to the emergency department with 2 days of worsening right lower quadrant abdominal pain and mild vaginal spotting. Her last menstrual period was 7 weeks ago, and she has not used contraception for the past year. She reports nausea but no vomiting or diarrhea. Vital signs: T: 37.3 °C, BP: 108/68 mmHg, HR: 92/min, RR: 16/min, SpO2: 99% on room air. Abdominal exam shows tenderness in the right lower quadrant without rebound or guarding. A urine pregnancy test is positive, and her serum β-hCG level is elevated but below the expected range for a 7-week intrauterine pregnancy. Transvaginal ultrasound does not show an intrauterine gestational sac. What is the most likely diagnosis?
A. Terminal ileitis
B. Ectopic pregnancy
C. Acute appendicitis
D. Rupture of ovarian cyst

Q41

A 29-year-old primigravida at 36 weeks of gestation presents to the maternity triage unit with continuous lower abdominal pain for the past 6 hours. The pain does not come and go in waves and is not associated with any leakage of fluid or vaginal bleeding. She denies uterine contractions, back pain, or change in fetal movements. Vital signs: T: 37.0 °C, BP: 112/70 mmHg, HR: 82/min, RR: 16/min, SpO2: 99% on room air. On abdominal examination, the uterus is gravid, tender over the fundus and right side, and measures consistent with 38 weeks size. Fetal heart rate is 145/min with normal variability. Speculum and digital examination show the cervical os is closed, long, and high. What is the most likely cause of her pain?
A. Active labor

B. False labor
C. Abruptio placenta
D. Red degenerative fibroid

Q42

A 28-year-old G2P1 woman presents to the emergency department with 7 weeks of amenorrhea and lower abdominal pain for 1 day. She has mild vaginal spotting but no passage of tissue. She has no significant medical history and has not used contraception. Vital signs: T 37.1 °C, BP 110/68 mmHg, HR 88/min, RR 14/min, SpO2 99% on room air. Pelvic examination shows mild left adnexal tenderness without cervical motion tenderness or active bleeding from the os. Transvaginal ultrasound reveals no intrauterine gestational sac and a 2.5-cm left adnexal mass with a small rim of free fluid in the cul-de-sac. Lab results: β-hCG 2800 mIU/mL, hemoglobin 12.2 g/dL, creatinine 0.7 mg/dL, AST 22 U/L, ALT 19 U/L. She is hemodynamically stable, desires future fertility, and is reliable for follow-up. What is the best next step in management?
A. Methotrexate
B. Bilateral salpingectomy
C. Left salpingostomy
D. Immediate laparotomy with salpingectomy

Q43

A 22-year-old G1P0 woman presents to the emergency department after a positive home pregnancy test and 1 day of severe, crampy lower abdominal pain without vaginal bleeding. She is approximately 6 weeks from her last menstrual period. Vital signs: T: 37.1 °C, BP: 112/70 mmHg, HR: 88/min, RR: 16/min, SpO2: 99% on room air. Pelvic examination shows a closed cervical os with mild cervical motion tenderness. Transvaginal ultrasound demonstrates a 15 mm anechoic intrauterine fluid collection without a visible yolk sac or fetal pole and no adnexal mass or free fluid. Her serum β-hCG is 1,600 mIU/mL (borderline for the typical discriminatory zone). What is the most likely diagnosis and the next best step in management?
A. Pregnancy of unknown location; repeat quantitative β-hCG and transvaginal ultrasound in 48 hours
B. Confirmed ectopic pregnancy; administer single-dose methotrexate now
C. Inevitable abortion; perform urgent uterine evacuation
D. Normal early intrauterine pregnancy; routine prenatal follow-up without further testing

Q44

A 28-year-old woman, who smokes one pack of cigarettes per day, undergoes an abdominal ultrasound for evaluation of nonspecific dyspepsia. Imaging incidentally reveals a 2.5-cm, well-circumscribed, hyperechoic lesion in the right hepatic lobe with features characteristic of a cavernous hepatic hemangioma. Liver function tests are normal, and she has no abdominal pain, weight loss, or systemic symptoms. She is worried and asks what lifestyle changes are necessary specifically for the hemangioma. What is the most appropriate advice?
A. Smoking cessation
B. Avoid sports

C. Avoid fat
D. Avoid protein

Q45

A 27-year-old man presents to the outpatient clinic with a 6-month history of crampy abdominal pain, non-bloody diarrhea, and a 6-kg unintentional weight loss. He also reports intermittent painful swelling near the anus that periodically drains pus. Colonoscopy shows areas of inflamed, ulcerated mucosa in the cecum and sigmoid colon separated by segments of normal-appearing mucosa. Biopsy of the affected areas demonstrates transmural inflammation with fissuring ulcers. Which of the following is the most likely diagnosis?
A. Ulcerative colitis
B. Crohn’s disease
C. Ischemic colitis
D. Irritable bowel syndrome

Q46

A 26-year-old G1P0 woman, LMP 7 weeks ago, presents to the clinic with 3 days of mild brownish vaginal discharge. She has no abdominal pain, no passage of tissue, and no significant bright-red bleeding. She feels well, has had mild nausea but no dizziness or syncope. Pelvic examination shows a closed cervical os with scant brown discharge and no uterine tenderness. What is the most likely diagnosis?
A. Missed abortion
B. Anembryonic pregnancy
C. Threatened abortion
D. Normal early intrauterine pregnancy

Q47

A 28-year-old man presents to the outpatient clinic with 6 months of intermittent crampy lower abdominal pain and non-bloody diarrhea occurring 4–5 times per day. He has unintentionally lost 5 kg during this period and reports fatigue. He also notes intermittent perianal discomfort and occasional drainage from a small opening near his anus. Colonoscopy shows patchy, discontinuous areas of inflamed mucosa involving the cecum and sigmoid colon with intervening normal-appearing mucosa. Biopsies reveal transmural inflammation with fissuring ulcers. Which of the following is the most likely diagnosis?
A. Ulcerative colitis
B. Crohn’s disease
C. Infectious colitis
D. Irritable bowel syndrome

Q48

A 25-year-old G1P0 woman at 7 weeks by last menstrual period presents to the emergency department with light vaginal spotting and mild lower abdominal cramping. Vital signs: T: 36.9 °C, BP: 118/72 mmHg, HR: 82/min, RR: 14/min, SpO2: 99% on room air. She reports no syncope or shoulder pain. Pelvic examination reveals a closed cervical os with minimal blood in the vaginal vault and no adnexal masses or significant tenderness. Transvaginal ultrasound shows no intrauterine gestational sac and no adnexal mass or free fluid. Quantitative serum β-hCG is 1200 mIU/mL (below the typical discriminatory zone). What is the most appropriate next step in management?
A. Diagnostic laparoscopy
B. Serial β-hCG measurement and repeat transvaginal ultrasound
C. Administer single-dose methotrexate
D. Immediate uterine evacuation (dilation and curettage)

Q49

An 18-year-old nulliparous woman presents to the clinic with a 1-year history of severe crampy lower abdominal pain during the first 2–3 days of her menses. The pain is associated with nausea and occasionally causes her to miss school. Her cycles are regular every 28 days with 5 days of bleeding, and she is sexually active with barrier contraception. She has tried scheduled ibuprofen during menses for the last 3 cycles with minimal relief. Pelvic examination is normal, and there is no dyspareunia, intermenstrual bleeding, or abnormal discharge. She wishes to improve her symptoms and is open to hormonal contraception. What is the most appropriate next step in management?
A. Start combined oral contraceptive pills
B. Order a pelvic ultrasound to evaluate for secondary causes
C. Schedule diagnostic laparoscopy
D. Reassure the patient and continue NSAIDs only

Q50

A 24-year-old sexually active woman presents to the emergency department with 2 days of lower abdominal pain and tenderness. She is unsure of her last menstrual period and has had occasional spotting over the past week. Pelvic examination shows mild cervical motion and adnexal tenderness; there is no obvious mass on bimanual exam. Vital signs are: T: 36.9 °C, BP: 118/72 mmHg, HR: 78/min, RR: 14/min, SpO2: 99% on room air. The physician is concerned about a possible early intrauterine pregnancy versus ectopic pregnancy. What is the best initial diagnostic test in this patient?
A. Serum β-hCG
B. Transvaginal pelvic ultrasound
C. Serum β-hCG and transvaginal ultrasound
D. Abdominal CT scan with contrast https://www.mysmle.com

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